Issued by MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS, DIVISION OF WORKERS' COMPENSATION

SELF-INSURERS' STATEMENT OF OUTSTANDING DISABILITY CLAIMS

_____, _____ _____ _____ _____ $_____

Date of Report | Name of Employer | Principal Address (Street No., City, State ZIP Code) | Nature of Business | Amount of Security

This information must be given.

State Injury Number	Name of Insured Person	Date of Accident	Average Weekly Wage at time of Accident	Weekly Compensation	Nature of Injury	If Injury is Permanent Total, Give Year of Birth	Probable Future Duration in Weeks	Estimated Total Future Payments F – For Final Award E – For Estimate	
	This report to include every claim either unadjudicated or pending for any reason such as third party action or otherwise.								

See Reverse Side

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SELF-INSURERS' STATEMENT OF OUTSTANDING DEATH CLAIMS

Injury Number	Name of Deceased	Date of Death	Average Weekly Wage at time of Accident		DEPENDENTS Include, with dates of birth, and remarriage, widows who have remarried					Do not write in this space (for Office use only)
					Give Name	Relationship	Year of Birth	Weekly Compensation		
	This report to include every claim either unadjudicated or pending for any reason such as third party action or otherwise.									

STATE OF _____ }
County of _____ } SS.

_____, being duly sworn, says that he/she is the _____

of _____, the employer referred to in the foregoing statement of death benefits or compensation due under the Missouri Workers' Compensation Law; that the foregoing statement is true to the best of his/her knowledge, information and belief after careful investigation and examination of the employer's books; that it comprises all claims for death benefits and for compensation now existing against said employer so far as he/she knows or has been able after diligent inquiry to find out, and that the ages of claimants, the amounts payable per week and the nature of disability, are in each instance correctly stated so far as possible from information at hand and that the estimated probable duration of disability is based upon a careful review of each individual case within two weeks of this date.

Sworn to before me, this _____ }
Day of _____, _____ }

_____

_____

NOTE – Self-insurers must include on this form every outstanding claim whether or not an award has been made.

Make notation as to disposition of any death or disability case previously reported and omitted from this report.

This report to be executed in name of the self-insured firm or individual